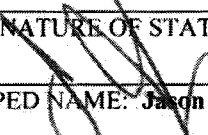
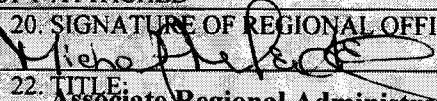


TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 13-06	2. STATE New York
FOR: HEALTH CARE FINANCING ADMINISTRATION		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE January 1, 2013	
5. TYPE OF PLAN MATERIAL (Check One): <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: Section 1902(a)(10)(C)(i)(III) of the Social Security Act Section 1905(w) of the Social Security Act		7. FEDERAL BUDGET IMPACT: a. FFY 01/01/13-09/30/13 \$ 2.65 Million b. FFY 10/01/13-09/30/14 \$ 3.53 Million	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Supp 1 to Att 2.6-A: Pages 8, 9 **SEE REMARKS BELOW		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Supp 1 to Att 2.6-A: Pages 8, 9	
10. SUBJECT OF AMENDMENT: Medically Needy Income Levels (FMAP = 50%)			
11. GOVERNOR'S REVIEW (Check One): <input checked="" type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: New York State Department of Health Bureau of HCRA Operations & Financial Analysis 99 Washington Ave – One Commerce Plaza Suite 810 Albany, NY 12210	
13. TYPED NAME: Jason A. Helgerson			
14. TITLE: Medicaid Director Department of Health			
15. DATE SUBMITTED: March 25, 2013			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED:		18. DATE APPROVED: April 29, 2013	
PLAN APPROVED – ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: January 01, 2013		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Michael Melendez		22. TITLE: Associate Regional Administrator Division of Medicaid and State Operations	
23. REMARKS: **This SPA proposes to increase the Medically Needy Income level effective 1/1/2013.			